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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **AMY ANN POLAKIEWICZ** **12309 Creek View Drive, Apt. 7** **San Diego, CA 92128** **Registered Nurse License No. 484958** Respondent.	Case No. 2011-95 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about September 30, 1992, the Board of Registered Nursing issued Registered Nurse License Number 484958 to Amy Polakiewicz (Respondent). The Registered Nurse License will expire on August 31, 2010, unless it is renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states, in pertinent part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . . .

7. Section 2762 of the Code states, in pertinent part:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

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(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

. . . .

8. Section 4022 of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription, "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a ____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

REGULATORY PROVISIONS

9. California Code of Regulations, title 16, section 1442, states:

As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

10. California Code of Regulations, title 16, section 1443, states:

As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

11. California Code of Regulations, title 16, section 1443.5 states:

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

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COST RECOVERY

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

13. "Phenergan" is the trade name for Promethazine HCI, a prescription drug which possesses anti-histaminic, sedative, anti-motion sickness, anti-emetic, and anti-cholinergic effects. It is considered a dangerous drug pursuant to Code section 4022.

FACTS

14. On July 13, 2008, Respondent was an employee of Access Nurses, and was working an assignment in the Emergency Department of Pomerado Hospital, in San Diego.

15. On that date, H.H., an employee of Pomerado Hospital known to Respondent, was admitted to the Emergency Department at approximately 2:30 a.m. and placed under the care of Respondent.

16. H.H. admitted herself for treatment after fainting while at work; she was nauseous, vomiting, and complained of multiple bouts of diarrhea over the last few days related to antibiotic use.

17. The physician ordered the insertion of an IV, the administration of fluids (IV Bolus of one liter Normal Saline wide open), and an initial dose of Phenergan 6.25 mg to be followed by two additional doses of 6.25 mg Phenergan if needed. There was no physician order for home injections or IV fluids. The charge nurse inserted a heparin lock, and Respondent administered the initial dose of Phenergan.

18. H.H. was discharged at approximately 5:45 a.m. by the Emergency Department physician with a diagnosis of dehydration and syncope.

19. At approximately 6:20 a.m., Respondent charted that H.H. had no further nausea or vomiting, and was discharged home with after care instructions. No prescriptions were given.

H.H. was to follow up with primary doctor, and was discharged "ambulatory." Respondent further charted that "the IV was discontinued" with the catheter intact.

20. Respondent discharged H.H. from the hospital with the heparin lock IV catheter still in place. Respondent provided H.H. with a "care package" including IV solution, tubing, syringes, and Phenergan so that H.H. could self-administer the medication at home. Respondent charted that the IV had been discontinued at the time of discharge when, in fact, she had deliberately left it intact and instructed H.H. on how to self-administer additional medication at home without a physician's order.

21. Respondent allowed H.H. to leave the hospital ambulatory, knowing that H.H. would be driving herself home at approximately 6:20 a.m. after receiving 6.25 mg of Phenergan at 4:15 a.m. Phenergan is a sedative medication with the effects lasting from two to eight hours after IV administration. It can cause dizziness and a transient lowering of blood pressure. Respondent advised another nurse that Respondent had not wanted to give H.H. "all of the Phenergan because she was getting sleepy and had to drive herself home."

22. In an interview with an the Division of Investigation investigator for the Board of Registered Nursing, H.H. stated that Respondent entered H.H.'s room carrying a yellow bucket and stated that she had something to give H.H. that would make her feel better when she got home. H.H. stated in the interview that she could not be sure what else Respondent may have said because H.H. was still pretty groggy from the Phenergan.

23. Upon arriving at home, H.H. noticed that the bucket contained a bag of saline, tubing, syringe, and possibly one dose of Phenergan. H.H. had young children in her home, and she was uncomfortable about mixing medication and attempting to administer it. She flushed the saline and Phenergan down the sink, bent the needles so that they were unusable, and threw the empty saline bag, tubing and syringe in the garbage.

24. Respondent admitted her actions to the charge nurse at Pomerado, who immediately contacted the Emergency Department Nurse Supervisor (EDNS) and advised her of Respondent's actions. The EDNS contacted both Respondent and H.H. H.H. confirmed that she had been sent

home with the IV in place, but that she had removed the IV herself and thrown away the supplies and Phenergan.

25. H.H. was requested to retrieve whatever items she could from the garbage and return them to the hospital. H.H. returned the empty bag of saline (1000 ml NS), empty vial of Phenergan (Promethazine vial 25mg/ml), two 3ml syringes, and two 18g needles.

26. As a result of this incident, Respondent's contract with Pomerado Hospital was cancelled and she was given a "do no return" status with Pomerado Hospital. Access Nurses did not renew their contract with Respondent as a result of this incident.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct- Gross Negligence and Incompetence)

27. Respondent has subjected her license to disciplinary action under section 2761(a)(1) of the Code, pursuant to California Code of Regulations, title 16, sections 1442 and 1443, in that Respondent exhibited an extreme departure from the standard of care as detailed in paragraphs 14-26, above. Respondent acted beyond her scope of practice in that Respondent discharged a patient with an IV intact, and sent the patient home with a dangerous drug and other supplies, and instructions to self-administer the drug, despite there being no physician's orders for this. Respondent discharged this patient to drive herself home within approximately two hours of the patient receiving an IV injection of Phenergan, a sedative, and Respondent noting that the patient was "sleepy." Respondent allegedly instructed the patient how to self-administer a dangerous drug, without a physician's order, while the patient was sedated with Phenergan and "sleepy." Respondent falsely charted that she had discontinued the patient's IV when she knew that this was false, and she intended to and in fact did discharge this patient with the IV in place for self-administration of a dangerous drug. Such unprofessional conduct is substantially related to the qualifications, functions, or duties of a registered nurse and evidences the present or potential unfitness of Respondent to practice in a manner consistent with the public health, safety, and welfare.

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct- Prescribe or Furnish a Dangerous Drug to Another)

28. Respondent has subjected her license to disciplinary action under section 2762(a) of the Code in that Respondent, on or about July 13, 2008, prescribed or furnished Phenergan, a dangerous drug, to H.H. as detailed in paragraphs 14-26, above. Such unprofessional conduct is substantially related to the qualifications, functions, or duties of a registered nurse and evidences the present or potential unfitness of Respondent to practice in a manner consistent with the public health, safety, and welfare.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Falsify or Make Grossly Inconsistent/Unintelligible Entries in Patient Record Pertaining to a Dangerous Drug)

29. Respondent has subjected her license to disciplinary action under section 2762(e) of the Code in that Respondent, on or about July 13, 2008, falsely charted that she had discontinued patient H.H.'s IV when she knew that this was false, and she intended to and in fact did discharge this patient with the IV in place for self-administration of a dangerous drug. Respondent failed to chart that she had discharged this patient with Phenergan and other supplies, and instructions for self-administration of same. Such unprofessional conduct is substantially related to the qualifications, functions, or duties of a registered nurse and evidences the present or potential unfitness of Respondent to practice in a manner consistent with the public health, safety, and welfare.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 484958, issued to Respondent Amy Polakiewicz;

2. Ordering Respondent Amy Polakiewicz to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 8/6/10

for LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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